Safeguarding Adults Review

‘Brian’

Hammersmith and Fulham Safeguarding Adults Board

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Contents

Introduction ……3
Terms of Refence ……3
Legal Context ……5
Methodology ……5
Family Involvement ……6
Background Information ……6
Overview of Agencies ……7
Chronology ……12
Analysis ……19
Good Practice ……32
Areas for development ……33
Recommendations ……33
Conclusion ……36

Introduction

1.1 Brian was a 50-year-old army veteran who experienced adverse physical and mental health issues, and substance misuse. He had also experienced homelessness and had been previously detained in prison. In February 2022 Brian attended hospital following a physical assault, he received a computerised tomography (CT) head scan and was discharged home. Five days later, following concerns raised by his tuberculosis (TB) nurse, police attended Brian's property and found him deceased.

1.2 The decision to undertake a Safeguarding Adults Review (SAR) was agreed following a Hammersmith and Fulham Safeguarding Board (H&FSAB) SAR Sub-Group meeting and this decision was endorsed by the H&FSAB Independent Chair in accordance with the Care Act 2014. The SAR sub-group meeting considered information provided by all the agencies involved with the person, who is the subject of this review, and following discussions concluded that there was reasonable cause for concern about how the H&FSAB members worked together to safeguard the adult who sadly died.

1.3 The purpose and underpinning principles of this SAR are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures[1]. All Hammersmith & Fulham Safeguarding Board (SAB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

1.4 This review has been anonymised, by referring to the person who is the subject of this review as Brian. This was done in accordance with H&FSAB's naming conventions for SARs and with agreement of the panel, in the absence of contribution from Brian's family.

Terms of Refence

2.1 A multi-agency panel was established by Hammersmith and Fulham SAB to conduct the reviews. Membership included a Lead Reviewer/Chair and representatives from key agencies with involvement.

2.2 The panel agreed that the review would cover the timeframe from 27th January 2021, when Brian was released from prison, to 15th February 2022 when he was found deceased. Any significant incidents relevant to the case

[1] London-Multi-Agency-Adult-Safeguarding-policy-and-procedures-2019-final-1-1.pdf (londonadass.org.uk)

but prior to the start date of the timeframe would be included in the analysis completed by each agency.

2.3 The purpose of the review is to identify multi-agency learning exploring information for the time period above under the following themes.

Adult Safeguarding best practice

i. How were safeguarding concerns appropriately responded to in accordance with the Care Act 2014 and London Multi-Agency Adult Safeguarding Adults Policy & Procedures?

ii. Was Brian able to appropriately advocate for himself?

iii. How were potential risks and the impact of those risks to Brian's wellbeing responded to?

iv. What examples are there of good practice?

Communication and Information Sharing

v. How effective was the multi-agency working and information sharing in relation to Brian and what challenges did agencies face in achieving this?

Application of the Mental Capacity Act

vi. How was application of the MCA 2005 considered in this case and how was decision making documented?

vii. How did practitioners balance the need to manage and mitigate risk, to and from Brian, with client choice and empower him to make healthy choices?

Equality and diversity

viii. What were the barriers to Brian seeking support, considering his unique experiences and protected characteristics? How were these considered and responded to by practitioners?

General

ix. What have been the key points of learning for each agency and what relevant changes have been put in place after the commissioning of this review?

x. How effectively are services able to recognise vulnerability of "difficult to engage" people? What is the impact of preconceived attitudes in recognising and acting upon these vulnerabilities?

xi. How are staff supported to work with adults at risk who are resistant to support? E.g., what evidence is there of access to reflective supervision?

xii. What was the effect of the Covid-19 pandemic on the care and support available to Brian or his access to services?

Legal Context

3.1 Under the Care Act 2014 Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs) in the following circumstances.

(1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if;

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if;

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if;

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether the local authority has been meeting any of those needs).

Methodology

4.1 The methodology used in this SAR was a blend of the traditional approach with analysis of combined chronology and Individual Management Reviews (IMRs) including critical reflection, and the systemic Learning Together approach which incorporated structured reflection with those involved in the case.

4.2 Agencies that had been involved with the adult provided information of significant contacts by preparing an agency chronology and outline report with a focus on the purpose and scope of the review. Other agencies/services were asked to provide reports or a chronology following review of the information provided.

4.3 Agency information included a brief analysis of relevant context, issues or events, and an indication of any conclusions. Information about action already undertaken or recommendations for future improvements in systems or practice were included where appropriate. A case summary also included any relevant additional background information from significant events outside the timeframe for the review.

4.4 A practitioner workshop was facilitated to ensure that all the relevant information was captured from the professionals involved in this case, whilst also providing an opportunity for reflection and development. The practitioner workshop explored hypotheses, drew out themes, good practice and key learning from the case including any recommendations for the development or improvement to systems or practice.

4.5 Consideration will be given to a Practice Learning event following completion of the review in order to share learning with a wide audience of practitioners.

Family Involvement

5.1 Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a Safeguarding Adult Review. A focus on their understanding about how their family member was supported daily and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events. Brian's sister was notified of the SAR but did not wish to participate in or contribute to the review.

Background Information

6.1 Brian was a 50-year-old white British man and an army veteran. He had two siblings, with Brian being the middle child. He came from a military family and described his childhood as being one of 'moving from base to base'. It is also reported that he experienced a violent childhood. Brian served five years in the Royal Corps of Signals. He joined at the age of 15 in 1986 and saw active service in the Gulf War in 1990/1991. He was medically discharged in 1991 following injury sustained by an Improvised Explosive Device. As a result of this, and a subsequent hip replacement, Brian mobilised with crutches. Brian experienced Post Traumatic Stress Disorder (PTSD) and had been diagnosed with dissocial personality disorder; he used alcohol and drugs, reportedly stating 'all I'm living to do is drink alcohol … I love alcohol'. He also had tuberculosis (TB) and human immunodeficiency virus (HIV). He had a history of violence and had been in prison, serving custodial sentences in 2018 and 2019, and 12 weeks in October 2021 for assaulting a police officer. It is reported that he was subject to twenty-two different sentences imposed by the Court from 2015.

6.2 The agencies that supported Brian reported a history of suicide attempts and suicidal ideation, and as a result had previously been admitted under section 2 of the Mental Health Act 1983.

6.3 Brian was in an 'on/off' relationship with a woman. The relationship was marked by regular reports to the police of verbal and physical assaults perpetrated by Brian, and on occasion perpetrated by his partner. This resulted in his partner being referred to the domestic abuse multi-agency risk assessment conference (MARAC) on six occasions between April 2018 and April 2021. There was subsequently a restraining order[2] in place against Brian yet despite this the couple remained in contact, instigated by both parties. As a result, Brian was in breach of the order leading to periods in custody. Not all professionals were aware of the restraining order that was in place. His partner referred to herself as a carer for Brian and could be supportive, although professionals also described the relationship as one of complex needs and co-dependencies. Brian was also at risk from others, on one occasion he was beaten with his own crutches.

6.4 Brian was also subject to a Community Protection Notice[3] from 5th February 2021 until 2nd February 2023, this acted to prevent him from entering specified areas of Hammersmith and Fulham; sitting, laying down or obstructing any public highway or pavement in England or Wales (unless in a medical emergency); possessing any article likely to be used in the course of begging; approaching people for money or donations; possessing prescribed drugs not in original packaging and named; and/or possessing articles for consuming controlled drugs.

6.5 Following the discovery of his body on the 15th February 2022 Brian's next of kin were informed and supported by specialist police officers. On the 20th February 2022 police arrested the alleged perpetrator and charged him with Brian's murder. After the investigation found no direct link between the assault and Brian's death, the charge was amended to grievous bodily harm to which the perpetrator pleaded guilty. The perpetrator was sentenced in March 2023 to fifteen months imprisonment, with time spent in custody to count towards sentence.

Overview of Agencies

7.1 The review identified several agencies who worked with and supported Brian in the final 14 months of his life. As such this section provides an overview of each of those agencies, their remit, and a brief synopsis of their involvement with him.

[2] Restraining orders are intended to be preventative and protective. The guiding principle is that there must be a need for the order to protect a person or persons. A restraining order is therefore preventative, not punitive. Restraining orders can only be made in respect of the defendant (not the victim or any witness). Restraining Orders | The Crown Prosecution Service (cps.gov.uk)
[3] s.43, Anti-social Behaviour, Crime and Policing Act 2014.

Adult Social Care, Hammersmith and Fulham

7.2 Hammersmith and Fulham Adult Social Care, as with other local authority adult social care departments across the country, are responsible for assessing the needs of people, who are ordinarily resident in their area, who appear to need care and support, and with planning to meet their eligible needs. They also have a duty to make enquiries when a person with care and support needs is experiencing, or at risk of experiencing, abuse and they are unable to protect themselves from harm.

7.3 Brian was known to adult social care from 2009 to 2022. He was an adult with care and support needs due to his physical disability, drug and alcohol dependency, and homelessness. Throughout the course of their involvement, adult social care received safeguarding concerns with a common theme around drug and alcohol use, self-neglect, and non-engagement with services.

Cassidy Medical Centre, North West London Integrated Care Board

7.4 Brian was registered with Cassidy Medical Centre from 19th October 2020 until his passing. Cassidy Medical Centre had direct contact with Brian on four occasions in relation to his registration with the surgery, hip pain, medication compliance and finally for a blood test, to which he did not consent and was subsequently issued with a warning for verbal abuse towards staff.

7.5 No safeguarding issues were identified, and the records made no reference to safeguarding referrals having been made or known about.

Charing Cross Hospital, Imperial College Healthcare NHS Trust

7.6 Charing Cross Hospital provides a range of acute and specialist services and a twenty-four/seven emergency department. Between 2019 and 2021 Brian had over thirty attendances and three hospital admissions between January 2020 and May 2021. The reasons for his presentations included seizures, intoxication, and falls. Brian was known to be aggressive and would often self-discharge. It was apparent that he was homeless and needed support with housing. In August 2020, the hospital identified social worker involvement and from that point the social worker was included in the discharge planning with the intention to support Brian with housing. No adult safeguarding concerns were identified or raised for him during his admissions to Charing Cross Hospital.

Chelsea and Westminster Hospital NHS Foundation Trust

7.7 Chelsea and Westminster Hospital NHS Foundation Trust operates over two main hospital sites, Chelsea and Westminster Hospital and West Middlesex University Hospital, and across 12 community-based clinics within North-West London. Both hospitals have major emergency departments, treating over 300,000 patients each year. The Trust also provides a specialist HIV care service.

7.8 Brian was diagnosed HIV positive on the 8th February 2001, attending outpatients for HIV treatment, and received TB care and treatment via the Trust's TB nurse.

7.9 Brian was seen regularly in the Emergency Department. Attendances most often related to a health crisis and in the context of his mental health diagnosis and alcohol consumption. At times behaviour such as spitting and throwing urine bottles prompted measures including being 'Red Carded'. This restricted Brian's access to anything other than emergency lifesaving care at Chelsea & Westminster Trust, however the TB nurses did continue to engage with Brian and support him with his medical treatment when it was clear that alternatives offered would not work for him.

7.10 The Trust did not raise any safeguarding concerns and were not aware of any safeguarding concerns being raised.

West London NHS Trust

7.11 West London NHS Trust is a provider of mental health, community, and social care. The Trust provides care and treatment for more than 800,000 people living in the London boroughs of Ealing, Hammersmith and Fulham, and Hounslow, delivering services in the community, hospital, specialist clinics and forensic (secure) units.

7.12 In the five years prior to his death, Brian received input from Hammersmith and Fulham Liaison Psychiatry Referral Screening, Hounslow Liaison Psychiatry, Hammersmith and Fulham inpatient occupational therapy, Hammersmith and Fulham Crisis Assessment and Treatment team[4],Ealing Adult Community Services, and the Rough Sleepers Mental Health Program (RAMHP)[5].

7.13 During the scoping period he received input from Hammersmith and Fulham Liaison Psychiatry Referral Screening in May 2021, the Crisis Assessment and Treatment team from February to June 2021, and RAMHP from August to October 2021. The service did not raise any safeguarding concerns during this period.

Westminster Court Diversion

7.14 The Westminster Court Diversion team, part of West London NHS Trust Criminal Justice Liaison and Diversion Services, provides screening, assessment, and ongoing referral for individuals within the Criminal Justice

[4] The crisis assessment and treatment teams (CATT) are a mental health service based in the community. They assess adults who're having a mental health crisis or need intensive home-based support and treatment. CATT teams aim to help people at home so they don't have to go into hospital. The teams are made up of multidisciplinary practitioners.

[5] The service responds to the needs of rough sleepers, who have mental health and physical health difficulties working with St Mungo's outreach service. They also provide support for rough sleepers who are in temporary accommodation.

System, that present with mental health issues and other vulnerabilities. Liaison and Diversion is an assessment service and do not carry caseloads.

7.15 The Liaison and Diversion service had several contacts with Brian between 2016 and 2021. They had one contact with him during the scoping period in February 2021 where he was seen at Westminster Magistrates Court for breach of the community protection order. Brian was provided with telephone numbers to contact the housing officer and probation.

Oxleas NHS Trust, HMP Wandsworth

7.16 Oxleas NHS Foundation Trust provides integrated primary care services within HMP Wandsworth. The services include low and high-intensity primary and social care interventions to adults and young offenders. This includes health, education, and activity programmes, as well as GP and nurse-led clinics that provide both emergency and planned care and long-term conditions management.

7.17 Brian was in Custody at HMP Wandsworth on the following dates during the scoping period:
23rd December 2020 – 28th January 2021

4th March 2021 – 5th May 2021

31st May 2021 – 5th August 2021

20th October 2021 – 21st December 2021

7.18 In addition, he was detained at HMP Wormwood Scrubs from the 19th to the 26th May 2021.

7.19 Whilst in custody no safeguarding concerns were raised.

Veteran's Service, Camden and Islington NHS Foundation Trust

7.20 The veteran's service works with veterans with mental health difficulties, in a range of situations. They offer assertive and intensive engagement to veterans via a pathway formerly called the 'High Intensity Service'. Brian was offered the High Intensity Service and a Veterans' prison in-reach service at HMP Wandsworth.

St Mungo's

7.21 St Mungo's is a charity that support people experiencing homelessness, to help them off the streets. Their outreach teams offer a bed and support to more than 2,800 people across the south and south-west each night. They believe that people can, and do, recover from the issues that cause homelessness. They work to prevent homelessness and support people at every step of their recovery from homelessness providing services such as outreach, accommodation, health support, offender services, care services, house clearing, recovery college, skills, and employment support.

Thames Reach

7.22 Thames Reach are commissioned by the London Borough of Hammersmith and Fulham to deliver visiting support to Housing First[6] clients. The service is aimed at people with a history of homelessness who have complex and multiple needs. The contract commenced on the 1st December 2021, prior to this the contract was held by St Mungo's.

7.23 Brian had an allocated keyworker at Thames Reach whose key focus was to support him to maintain his accommodation and prevent him from returning to street homelessness.

Turning Point

7.24 Turning Point is a drug and alcohol service providing support ranging from one-to-one key-working, to group work, prescribing and access to in-patient options. The team will support people to build a treatment plan based on their circumstances. They also provide specialist support for the friends and family of drug users.

7.25 Brian was known to Turning Point's Drug and Alcohol Wellbeing Service from 2016 via the Prison Release Alert process. He had one treatment episode in 2017 having been sentenced to an Alcohol Treatment Requirement. Engagement was sporadic with appointments missed, leading to closure after a 6-month period.

7.26 There were further engagement attempts, with a Prison Release Alert received 16th December 2021 advising that Brian was to be released from custody on the 21st December 2021. This left insufficient time to complete an assessment whilst he was still in custody. No client contact details were noted on the Prison Alert. Consequently, a letter was sent to Brian, via the prison, advising him to contact the service upon his release. No contact was received from Brian, and he was discharged from the Drug and Alcohol Wellbeing Service on the 24th February 2022 due to non-engagement.

Probation

7.27 The Probation Service supervises offenders released into the community, while protecting the public. They are responsible for sentence management in both England and Wales, along with Accredited Programmes, Unpaid Work, and Structured Interventions. Their priority is to protect the public by the effective rehabilitation of offenders, by reducing the causes which contribute to offending and enabling offenders to turn their lives around.

7.28 Brian came to be known to the Probation Service from 2015, when he was 45 years of age. However, his offending history commenced from the age of 18

[6] Housing First is an internationally recognised approach to tackling homelessness for people who have been unable to sustain long-term accommodation. It provides a tenancy first as a platform for change, with intensive and flexible support to help clients address their needs at their pace.

and went on to consist of convictions for assaults, drunk and disorderly, and racially aggravated offences.

7.29 Regarding Brian's last period of probation supervision, he was released from prison in January 2021 and accepted a flat in March 2021. He was consistently associating with others who were addicted to illicit substances.

7.30 Brian was subject to twenty-two different sentences imposed by the Court from 2015, the majority of which were to be supervised by the Probation service, however, despite numerous attempts and leniency from Probation Practitioners, he was reluctant to engage and became racially abusive during most of his sessions.

7.31 Adult safeguarding referrals were not undertaken as Brian had supported housing and an active support worker.

Metropolitan (Met) Police Service

7.32 The Met polices 620 square miles, serving more than eight million people across 32 boroughs within Greater London. The most reported crimes are sexual and violent offences, anti-social behaviour, and vehicle crime[7].

7.33 The Met Police provided details of contact with Brian dating back to 2017, involving assaults upon and arguments with his partner, breaches of the restraining order, two suicide attempts and GBH by an unknown perpetrator.

7.34 During the scoping period, the Met Police recorded that they responded to a report to Brian sleeping rough on a bus and racial abuse of the bus driver in January 2021. They arrested Brian in March 2021 for breaching the restraining order, and again in May 2021 for racially aggravated public order threats, for which he was charged. The Met's final encounter, prior to his death, was in response to an argument between Brian and his partner in January 2022.

Chronology

8.1 Brian was detained at Wandsworth prison between the 23rd December 2020 and the 28th January 2021. A prison alert was received by Turning Point the day prior to his release, Turning Point wrote to Brian inviting him to make contact for support in the community, however he did not respond.

8.2 On the 29th January 2021 Brian was taken to Chelsea and Westminster hospital by the London Ambulance Service having been found collapsed and intoxicated. Brian presented with behaviour that challenged; he was non-compliant and left the department. Brian was later returned to the hospital by ambulance due to seizures, caused by non-compliance with medication. Brian

[7] Hammersmith Broadway | Your area | Metropolitan Police | Metropolitan Police

was verbally abusive to staff and absconded from the department. He was found by police three hours later however he had been medically cleared and there was therefore no need for his readmission.

8.3 On the 3rd February 2021 Brian was taken again to Chelsea and Westminster hospital by ambulance due to nausea and abdominal pain. His bloods were stable, and he was discharged with safety advice.

8.4 Adult Social Care received a safeguarding concern from St Mungo's on the 15th February 2021 which stated that Brian had been released from prison on the 27th January 2021 without his support network being informed. This meant he was unable to be supported to safely return home and make a personal safety plan, and as a result he had breached his bail conditions as he had no support to comply. There were also concerns of cuckooing with other individuals being found in his flat using illicit substances. The concern referred to Brian's 'extremely high level of vulnerability' which included physical disabilities and positive HIV status; complex mental health issues including PTSD and high levels of depression; alcohol dependency and high support needs around finances with a history of being financially exploited; support around offending and managing the relationship with his partner; unsociable behaviours in public including prolific begging.

8.5 Adult Social Care discussed case with St Mungo's, who reported they were now supporting Brian with picking up and dropping off medication. They confirmed he was engaging with the Veteran's Service, who saw him once a week. St Mungo's agreed to consider offering occupational therapy as part of their work. Adult Social Care advised there was no role for adult safeguarding and closed the referral.

8.6 On the 2nd March 2021 Brian breached the restraining order; he was arrested and detained in Wandsworth prison from the 4th March 2021 to the 5th May 2021.

8.7 On the 5th May 2021 Brian was taken to Charing Cross Hospital by ambulance after being found collapsed in the street. Brian said he had been drinking. He was intoxicated in the Emergency Department but medically stable. He had a CT head scan which was normal. He was discharged the following day with homelessness advice.

8.8 An hour after his discharge Brian presented at Charing Cross Hospital after falling, sustaining a small head injury. He had multiple seizures and was admitted to a medical ward. Brian had a bad cough and was placed under supervision due to his seizures. He had some hematemesis[8] and a gastroenteritis[9] review was requested due to previous gastroenteritis bleed. It

[8] Expulsion of stomach contents mixed with blood, or blood only through the mouth.
[9] A condition characterised by irritation and inflammation of the stomach and intestines. This causes diarrhoea, vomiting and nausea.

was also noted that he was under the John Hunter Clinic for HIV. It was stated that he had a complex social history, and the complex discharge team would need to be involved. An urgent CT chest, abdominal and pelvis scan was also requested to rule out malignancy.

8.9 During his admission it was agreed to transfer Brian to the Chelsea and Westminster Hospital as they knew him well. On the 12th May he was transferred to Hammersmith Hospital for a bronchoscopy[10]. Brian was then transferred from Hammersmith Hospital to Chelsea and Westminster Hospital; he was escorted by two police officers as he had been under arrest for GBH and spitting at police. TB treatment commenced the same day, but Brian was non-compliant.

8.10 Liaison psychiatry reported that Brian's actions appeared 'very much intentional and out of frustration at not being allowed his freedoms while under arrest and in keeping with his known ASPD [anti-social personality disorder] diagnosis. He has refused liaison psychiatry input and there are no acute concerns around [mental health] and he said he would see the psychiatry team in person which is acceptable… There is no indication of liaison psychiatry input, and we will discharge him back to the medic. If any acute changes to mental health presentation or episodes of self-harm we can attempt to review again'.

8.11 Brian was transferred to a single room due to non-compliance and risk to staff secondary to pulmonary TB. Due to his aggressive and intimidating behaviour to staff and damage to his side room, he was arrested and charged with racially aggravated public order threats and was taken back to prison on the 22nd May 2021. He was detained at Wormwood Scrubs until the 26th May 2021.

8.12 On the 26th, 27th and 28th May 2021 the TB Clinical Nurse Specialist attempted home visits to Brian to provide Directly Observed Therapy, this meant watching Brian take his TB medications. A risk assessment determined that Directly Observed Therapy would be provided on the doorstep due to risk to practitioners. During the three home visits Brian did not engage, would not open the door, or confirm he would take any of his medications.

8.13 On the 29th May 2021 Brian was found lying on the floor, awake, alert, no injuries and smelling of alcohol and was taken to Chelsea and Westminster hospital. Brian's medications and compliance were reviewed, noting that when he was released from Wandsworth on the 5th May 2021, he had two weeks' worth of medication. Brian could not recall medications or doses and believed he had left his medications at a friend's. The community pharmacy informed ICHT that they had not dispensed his medication since December 2020. Upon examination by a doctor Brian became aggressive and refused the remainder

[10] A procedure to examine the airways

of the examination. A consultant also reviewed Brian, he was discharged and left the department himself after being re-prescribed all his regular medications.

8.14 On the 31st May 2021 Brian was found on the pavement refusing to move. Police and ambulance were called. He was taken to the Emergency Department with low temperature but declined any treatment or investigations. He was discharged to police custody once his temperature returned to normal.

8.15 Brian was detained at Wandsworth prison from the 31st May 2021 to the 5th August 2021. During which time, Turning Point closed their involvement due to non-engagement on the 8th June 2021.

8.16 On the 22nd July 2021 Brian was red carded from Chelsea and Westminster Hospital for one year due to persistent verbal and racial abuse, physical aggression and intimidation, and destruction of hospital property. He was therefore referred to St George's tuberculosis team. St George's reported they had no staff for community visits and therefore the Chelsea and Westminster tuberculosis nurse would remain in contact with Brian. Public Health teams were informed that Brian had been released from prison without any tuberculosis medication.

8.17 On the 4th August 2021 Brian was taken to West Middlesex emergency department by ambulance after being found by the police custody officer having a seizure. Brian had sustained a head laceration and was given a CT head scan. He was given a verbal warning due to his behaviour in the department and was discharged home.

8.18 On the 6th August 2021 Brian attended West Middlesex emergency department with seizures and was then detained into police custody for being drunk and disorderly. The hospital liaised with his housing team at St Mungo's to deal with the broken lock on his door and make his flat safe. Contact was also made with veteran health and the UK Health Security Agency.

8.19 Also on the 6th August 2021, London Fire Brigade raised concern with adult social care that Brian was not managing his activities of daily living. This was not progressed to a safeguarding enquiry as the most appropriate route for support was determined to be a Care Act assessment. The need for assessment was passed to the community response and reablement team for allocation.

8.20 On the 8th August 2021 Brian was taken to Charing Cross hospital by ambulance and in police custody, having spat in a police officer's face. The police had witnessed Brian having a seizure so phoned for an ambulance. Brian was reviewed and discharged, he was cleared as medically fit and was treated for an uncomplicated alcohol withdrawal. He was given a small dose

of alcohol withdrawal medication and left with a prescription of his regular medications for epilepsy.

8.21 On the 9th August 2021 the tuberculosis nurse visited Brian's home. The door to his flat was open but Brian was not there. On investigation, it was found that he had been at Charing Cross hospital.

8.22 On the 10th August 2021 the tuberculosis nurse put an alert on the agency's system in case Brian attended Chelsea and Westminster so that he could have sputum collected and a chest x-ray.

8.23 On the 13th August 2021 a multi-disciplinary team (Housing/Homeless outreach/UKHSA) met to discuss Brian. The team noted that Brian was not engaging. He was to be referred to Find and Treat, tuberculosis outreach workers[11].

8.24 On the 17th August Brian was taken to Chelsea and Westminster Hospital following a seizure which caused a bruised and swollen eye. Brian refused examination and his behaviour was threatening. He was therefore escorted from the hospital by security staff.

8.25 On the 21st August 2021 Brian was taken to Chelsea and Westminster Hospital intoxicated. He was abusive and violent to staff and escorted off the premises by security.

8.26 On the 22nd August 2021 Brian attended Chelsea and Westminster Hospital. He was intoxicated and discharged himself. He presented again later with hip pain. He left after assessment and before any treatment.

8.27 On the 7th September 2021 the tuberculosis nurse attended the multi-disciplinary team to review Brian's housing and tuberculosis treatment. The nurse contributed to attempts to locate Brian in the area.

8.28 On the 28th September 2021 a meeting took place with the Probation Practitioner, Rough Sleeping Prevention manager LBHF, Drug Treatment services and mental health services. Discussion centred about keeping Brian out of prison because he would lose his accommodation. The Rough Sleeping Prevention manager agreed to continue to complete welfare checks and make a safeguarding referral.

8.29 On the 1st October 2021 St Mungo's submitted a referral to Adult Social Care citing concerns about Brian managing activities of daily living. As there was

[11] Find&Treat are a specialist outreach team that work alongside over 200 NHS and third sector front-line services to tackle TB among homeless people, drug or alcohol users, vulnerable migrants and people who have been in prison. The team are multidisciplinary including former TB patients who work as Peer advocates. Their aim is to take TB control into the community, find cases of active TB early and support patients to take a full course of treatment and get cured.

nothing new in this report from that reported on the 6th August 2021 it was forwarded to the community response and reablement team, which in turn was passed to the substance misuse social worker.

8.30 On the 18th October 2021 the substance misuse social worker attended a professionals meeting with St Mungo's, West London NHS Trust and Camden and Islington NHS Foundation Trust. The meeting noted that Brian's primary issue was financial as he had had his Personal Independence Payment (PIP) removed, and West London NHS Trust were supporting Brian to get his PIP reinstated. It was also noted that Brian's living conditions were 'very poor'. The substance misuse social worker identified no further action for themselves and would await further invites to future meetings.

8.31 Brian was detained at Wandsworth prison from the 20th October 2021 to the 21st December 2021 following assault of an emergency worker.

8.32 On the 1st December 2021 the Veteran's Service received a referral prior to Brian's release from prison. The Veteran's Service discussed Brian at a multi-disciplinary meeting. The service advised it was not going to proactively engage Brian after release from prison, but rather offer veteran-sensitive advice to other involved services if requested. On the 16th December 2021 Turning Point received a Prison Alert from Wandsworth Prison. Turning Point sent a letter to the prison for Brian to contact the service on his release.

8.33 Between the 22nd December 2021 and the 10th February 2022, the tuberculosis nurse visited Brian daily (Monday to Friday) to undertake the Daily Observed Therapy[12]. He engaged with the support relatively well during this period.

8.34 On the 8th January 2022 police responded to an argument between Brian and his partner.

8.35 On the 11th January 2022 the Thames Reach worker met with Brian and took him to the job centre to collect money vouchers. The following day the support worker accompanied Brian to Court for an offence of assaulting a Police Officer, committed in early 2020. Brian had previously pleaded guilty to breaching a restraining order which was the original offence that he was arrested for when the alleged assault took place.

8.36 On the 19th January 2022 the Thames Reach support worker visited Brian as he had not seen him since the previous week. The support worker was concerned at his presentation as he said that he just been sick. Brian did not remember the worker from the previous week or any of the previous times

[12] Directly observed therapy (DOT) is used to ensure the person receives and takes all medications as prescribed and to monitor response to treatment. DOT is widely used to manage tuberculosis (TB) disease. In HIV treatment, DOT is sometimes called directly administered antiretroviral therapy (DAART).

that they had seen him. The support worker phoned adult social care to raise their concerns. The worker noted an on-going issue with the boiler not working in Brian's flat and the flat being in 'disarray'. The Thames Reach worker raised the boiler issue with housing.

8.37 The safeguarding concern was received by adult social care which detailed concerns following Brian's release from prison in December 2021, that he may not be feeding, clothing, or cleaning himself properly, and that he would benefit from an assessment. The decision was taken that the concern did not meet the criteria for a safeguarding enquiry. It was recognised that the previous request for assessment in October 2021 did not proceed due to Brian being detained in prison, therefore this request was again passed to the community response and reablement team for a Care Act assessment.

8.38 Thames Reach visited Brian again on the 20th January 2022 to advise him that he had a payment waiting for him at the Job Centre. Brian said that he would go later, after he had been visited by the nurse.

8.39 On the 1st February 2022, Thames Reach supported a joint visit with the Social Worker. Brian's flat was observed to be 'unkempt and cluttered' and both he and his partner appeared intoxicated. The social worker asked Brian what help and support he wanted but he refused, saying he would not allow access for any support to be provided and just wanted to be left alone. He said that nobody had come to sort out his electric/gas. Brian was informed that attempts had been made but he had been out. He said that he could not wait in for repairs as he was an alcoholic and needed to go out to buy alcohol. Brian's partner was present and they both were becoming agitated so both practitioners left. Following the visit Thames Reach contacted housing about the gas and electric.

8.40 On the 4th February 2022, Thames Reach contacted Housing Options to resolve Brian's rent arrears and attended his flat to meet the gas repair man.

8.41 On the 7th and 8th February 2022, Thames Reach visited Brian at his flat and on both occasions, he told the worker to go away.

8.42 On the 10th February 2022, the tuberculosis nurse visited Brian. He had been assaulted by a person known to him. He was encouraged to attend hospital urgently, but he was reluctant to attend as he wanted to go and get his benefits.

8.43 However, Brian did attend Chelsea and Westminster Hospital with bruising to his forehead and left eye and vomiting. A small brain bleed was identified via a CT scan and a decision was made to admit him, however, as Brian had a red card in place the plan was to transfer him to St George's.

8.44 Brian was cleared by neurosurgeons on the 11th February 2022. Brian was aggressive and agitated when informed of his discharge, security was called and he left the department. He also said that he now felt unsafe in his flat and wished to move.

8.45 Thames Reach and the tuberculosis nurse liaised on the 11th February. The nurse advised that Brian had been discharged from hospital and that she would undertake a welfare check on Monday 14th February 2022. Thames Reach notified the rough-sleeper coordinator of the assault and raised a safeguarding concern with Adult Social Care. Adult Social Care spoke to both Thames Reach and the TB nurse, and attempted to call Brian although he did not answer. The nurse notified the police who planned to do a welfare check over the weekend.

8.46 When the tuberculosis nurse visited on the 14th February 2022 Brian was not at home. This did not cause concern as this had been his usual behaviour over the previous few weeks.

8.47 On the 15th February 2021 the social worker emailed the TB nurse asking if they would advise whether Brian had received any further updates from the police and could she assist adult social care in liaising with him regarding consent to the safeguarding concern raised on his behalf.

8.48 The nurse attempted to visit Brian on the 15th February 2022 but again he was not home. She informed Thames Reach who confirmed they were planning to see Brian on the 16th February. The nurse called again at Brian's flat, he appeared to still be out. Concerned about his welfare, the nurse contacted the police. Police attended and Brian was found deceased inside the property.

Analysis of themes identified in the terms of reference.

9.1 The following analysis responds to the themes identified in the terms of reference, drawing upon the IMRs, chronologies and reflections from the practitioner workshop, and with reference to law, guidance, policy, procedure, and research.

Adult Safeguarding processes

Safeguarding concerns and responses

9.2 During the scoping period five safeguarding concerns were raised, St Mungo's reported that there were also informal discussions with the Multi-Agency Safeguarding Hub around action that could be taken and safety planning.

9.3 The first concern was raised by St Mungo's on the 15th February 2021 highlighting Brian's vulnerabilities and ability to maintain his safety, with concerns that he might be being cuckooed. Adult Social Care were satisfied

that he was being supported by St Mungo's and the Veteran's Service and so no further action was taken.

9.4 The second concern was raised by the London Fire Brigade on the 6th August 2021 who reported concerns about Brian being able to complete activities of daily living, which may have suggested possible self-neglect. Adult Social Care considered the most appropriate response was to undertake a Care Act assessment.

9.5 The third concern was raised by St Mungo's on the 1st October 2021 again relating to Brian's ability to meet his basic needs and maintain his environment. The matter was passed to the allocated social care worker. The Care Act assessment highlighted following the August report was not subsequently undertaken due to Brian's detention in prison. A further concern was raised by Thames Reach on the 19th January 2022 which resulted in a joint visit to undertake the Care Act assessment. Brian was clear that he did not want any support arranged for or provided to him.

9.6 The fifth and final concern was raised by Thames Reach following the physical assault of Brian. Following the assault Brian stated that he felt unsafe in his flat and wanted alternative accommodation. Brian died before a safeguarding enquiry could be initiated. Practitioners reflected that whilst more could have been done to prevent him returning to his flat on the 11th February 2022, Brian prioritised his getting his benefits due to his dependency on alcohol.

9.7 The first four concerns that were raised indicated that Brian was experiencing, or at risk of experiencing, abuse, or neglect and as a result of his care and support needs, he would likely be unable to protect himself against the abuse or neglect or the risk of it,[13] therefore the duty to make enquiries would have been triggered. However, whilst it seems reasonable and proportionate to have responded by undertaking a social care assessment, the commencement of that assessment was interrupted by Brian's incarceration in prison and ultimately, he did not engage well with the assessment and declined any other services or support. A safeguarding enquiry would have provided the framework to identify the risks more robustly and provide for a multi-agency response to explore the management of risk.

9.8 The review noted the relatively low number of safeguarding referrals made given the number of agencies involved. Agencies surmised that compassion fatigue and unconscious bias might have been at play. The police reflected that Brian had assaulted police and emergency workers and that at the time this might have changed their response to him.

[13] Care Act 2014, s42(1)

9.9 However, Adult Social Care noted that a lot of people were doing a lot of things to mitigate risk around Brian and were trying to engage with him to make positive changes. The service wondered whether it was less about the number of referrals and more about whether Adult Social Care responded appropriately to the information they did receive. That is, how they screen safeguarding concerns when there are several complexities, including questions around capacity.

Identifying, assessing, and managing risk

9.10 The combination of physical and mental health issues Brian experienced likely placed him at greater risk of abuse, and of neglecting his own needs. Thames Reach completed a risk assessment on 31st January 2022 which identified the key risks to Brian as being: loss of tenancy due to rent arrears, deterioration in physical health due to medication compliance and substance misuse, and risk of a return to prison due to offending behaviour and breaches of orders. Brian was contacted and visited frequently by Thames Reach due to concerns about his wellbeing. In the month before his death, he was met by Thames Reach staff on the 11th January, 12th January, 19th January, 20th January, 21st January, 24th January, 1st February, 4th February, 7th February, and 8th February. The service contacted other professionals to express concerns, including Adult Social Care to raise safeguarding concern and arrange assessments, Hammersmith and Fulham Housing about arrears and condition of the property, and the TB specialist nurse.

9.11 Brian was non-compliant with critical medication for epilepsy, HIV and TB. His non-compliance was documented on multiple occasions by Chelsea and Westminster Hospital NHS Foundation Trust and Imperial College NHS Health Trust and other agencies were aware. The risk of non-compliance with TB and HIV medications is that this can lead to treatment resistance, and may result in longer and/or more complex drug regimens being needed.[14] Non-compliance with epilepsy medication would lead to an increased risk of experiencing seizures, and injury therefore.

9.12 On each presentation to ICHT services Chelsea and Westminster were notified, any discharge summaries of inpatient stays were shared with his team at Chelsea and Westminster and with his GP. Reassurance that Brian would also have access to a pharmacy was sought by contacting his key worker at Thames Reach, who collected his medications. The Hepatitis C team would visit Brian's flat fortnightly to encourage him to take his medications, the TB nurse undertook daily observed therapy and would attempt to see him multiple times throughout the day, including trying to see him on the street where he was known to beg. The TB nurse was proactive in

[14] Tuberculosis (TB) - Treatment - NHS (www.nhs.uk); Scenario: Established HIV infection | Management | HIV infection and AIDS | CKS | NICE

their approach in also taking the opportunity to review Brian in the emergency department and linking in with the GP to inform them of his non-compliance.

9.13 There were concerns about Brian's ability to clean, feed, and clothe himself and reports that his flat was in a state of 'disarray;' this included issues with his gas and electric supply in early 2022. Along with his non-compliance with medication it is evident that he was self-neglecting.

9.14 Brian was also vulnerable to financial exploitation from his partner and his peers who would often ask him for money, which he would provide them with. Most of his money came from begging which meant any form of financial plan around harm minimisation was difficult to manage.

9.15 It was further reported that Brian might have been being cuckooed but this was not explored further. Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation. Perpetrators of cuckooing target vulnerable people, establishing a relationship to access their home. Once the perpetrators gain control over the victim larger groups will sometimes move in. If the victim asks the criminals to leave, then manipulation, threats or actual violence may be used. The London Borough of Hammersmith & Fulham have launched the Cuckooing Risk Panel to safeguard victims of cuckooing. Professionals can make a referral to the panel where they have concerns that a vulnerable individual is being cuckooed. The multi-agency panel will discuss options for increasing the safety for victims and addressing the perpetrators' behaviour and turn these into coordinated action plans[15].

9.16 There were also historical reports that he experienced physical assault from others and had a history of suicidal ideation and suicide attempts. West London NHS Trust had undertaken risk assessments which identified a risk to self, due to a history of suicide attempts, and a significant risk to others due to his offending history, no significant risk was identified in respect of risk from others. Although there was nothing to suggest an escalated risk during the scoping period, given Brian's experience of homelessness, mental health, and substance misuse this would have remained a risk.

9.17 Once an escalation in risk was identified probation took enforcement action to contain Brian to reduce the risk to himself and others. Professionals' meetings were held, and risks were shared in interagency meetings. These meetings were held in May, June, September 2021, and December 2021 and included Mental Health services, accommodation, medical practitioners, Probation practitioners, local authority accommodation, drugs and alcohol services, veteran's services, and victim services.

[15] Cuckooing | LBHF

9.18 It is evident that agencies working with Brian were able to identify risks, and in the main risk was assessed and managed at a single agency level. Practitioners reflected through the practitioner workshop that the High-Risk Panel could have been a suitable forum to manage risk. The High-Risk Panel was established to respond to cases of self-neglect, where there remains a significant risk from hoarding, fire risks, self-neglect, and complex homelessness, and aims to support partner agencies to work together to reduce and manage risks. Suitable cases include those of greatest concern to the agency, which are particularly complex and have reached a "sticking point" through single-agency action. The panel discusses the cases presented to them with a view to determining next steps, to challenge, advise and support the 'presenting agency', as well as identifying multi-agency solutions and action plans. The panel may also assist with the coordination of cases where there are multi-agency barriers. Adult Social Care suggested that at the time of their involvement, a referral to the High-Risk Panel would have been something to consider having first thought about what other interventions could be considered.

9.19 Practitioners also highlighted the Street Population Action Partnership (SPAP) as a forum to manage the risks to Brian. The SPAP is a multi-agency meeting where information and intelligence is shared, and action plans are coordinated, in relation to cases of entrenched rough sleeping, street activity and Anti-Social Behaviour (ASB) from members of homeless and street population. The SPAP aims to take an early intervention approach to dealing with those at risk of harm, and causing harm and ASB to others, using enforcement only where necessary. The primary focus of the SPAP is to assist the Council and its partners to take a multi-agency, supportive and compassionate approach to dealing with cases of street activity from at-risk individuals. Cases should only be referred to the SPAP if (a) previous involvement and interventions from relevant professionals/partners have been unsuccessful (and therefore an alternative approach is required); or (b) professionals involved in the case are considering an enforcement approach.

9.20 Whilst the core members of the High-Risk Panel and the SPAP differ, there is the option to extend to 'non-core' members for both. It is evident that Brian could have met the criteria for either group and the use of either forum would have enabled the agencies involved to share information, assess, manage, and possibly reduce the risks to him.

Multi-agency working: Communication and Information Sharing

9.21 There were up to fourteen agencies working, or involved, with Brian at various times depending on his location, whether that be in the community, in hospital or in prison. It could be difficult for agencies to keep track of where he was at any given time and the transient nature of the case meant that there was a stop/start of service provision by the various agencies depending on whether Brian was in the community or in custody.

9.22 It could be difficult for professionals to identify which services or professionals were involved. Oxleas NHS Trust commented on the 'scattergun' approach to information sharing, that there were thirty to forty individuals copied in to emails and it was unclear who was involved or responsible, or indeed whether the right people were being copied in. This may have caused recipients to assume that someone else was responsible and would respond, with the risk that nobody was taking responsibility or responding. In addition, given that there were often multiple agencies involved it was difficult to know who the best person was to contact, for example, more than eight agencies were involved at the point of Brian's last release from custody. Agencies also commented that the volume of emails being sent and received made it difficult to coordinate and difficult to keep track of what was happening, what other agencies were doing and what had happened to referrals that had been made.

9.23 Despite these difficulties agencies did share information. As stated above, Thames Reach shared information with Adult Social Care, housing, and the TB nurse; Charing Cross Hospital shared information with Chelsea and Westminster following attendances and admissions and tried to engage with social workers, key workers and next of kin where possible so that someone was aware of Brian's location; Wandsworth Prison notified Turning Point when Brian was due for release from prison.

9.24 There was evidence of good multi-agency working and communication when Brian was due for release from prison. Agencies communicated and worked together to ensure that Brian was supported by professionals to return to his accommodation upon release, this included arranging transport for him from prison to his home, ensuring that he had his keys to access the property and sufficient medication when he returned home. The relevant agencies were also notified so that they could resume their support to Brian.

9.25 Multi-agency meetings appeared to focus on the specific issues arising at the time, as known by the participating agencies. Cassidy Medical Centre commented in their report that the GP was not invited to any inter-agency meeting to discuss Brian, share information, and care plan holistically for him, neither did Cassidy Medical Centre coordinate any multi-disciplinary meeting, although recognised that this would have been advantageous at the point of Brian's release from prison.

9.26 At the practitioner workshop, practitioners suggested that the use of forums such as the High-Risk Panel and the SPAP may have been suitable fora for multi-agency discussion. The issue highlighted for the practitioners was who would be the lead agency and who would be responsible for making the referral. In this case there was no lead agency and if there had been one this would have been fluid dependent on where Brian was or the primary presenting need at any one time.

Application of the Mental Capacity Act

9.27 It appears that although Brian's judgement was often impaired by drug and alcohol use, and that his decisions often appeared unwise, it was felt that he had mental capacity to make decisions. Many practitioners stated that they had been given no reason to question Brian's mental capacity. Wandsworth Prison stated that, apart from when he was suspected to be intoxicated, he was always deemed to have capacity whilst in custody; there was nothing in his medical records that suggested that mental capacity was a concern. Some agencies recognised that his mental capacity fluctuated but nevertheless did not identify a cause to formally assess his mental capacity i.e., there was no specific decision to be made and the principle of assumed capacity unless there is reason to believe otherwise.

9.28 Brian was deemed fit to follow the Court and Criminal Justice process and this was clearly documented. However, assessment at Court is more to determine if the defendant is fit to proceed with court process rather than assessing mental capacity, although the practitioner talked through his ability to weigh up decisions.

9.29 Probation reflected on whether they should have requested a mental capacity assessment; they had offered this to Brian but he declined. The TB nurse also noted that her priority was to maintain Brian's engagement with medication. His compliance with medication was 'good enough' and there was therefore no need to assess his mental capacity.

9.30 The court liaison service had documented that Brian clearly understood the physical and mental health risks of chronic and increasing alcohol use, as this was actively explored with him. He informed the practitioner that he did not want to stop drinking and did not consent to any referral to drug and alcohol services. The practitioner attempted to explore this but he remained avoidant of discussing the issue further.

9.31 Many practitioners reflected on Brian's very explicit statement that alcohol was all he lived for and that completing capacity assessments when someone is intoxicated is very complicated. In St Mungo's opinion his mental capacity would come and go depending on the level of his intoxication and potential triggers around PTSD. Oxleas NHS Trust noted that during their engagement Brian was assessed as having mental capacity, though he had just completed detox whilst in custody and was not under the influence of any substances. The Veteran's Service said that there was not one occasion when Brian was not influenced by alcohol, and recalled that on one occasion, despite being intoxicated, he was able to list all the medication that he was expected to take.

9.32 With regards to his ability to advocate for himself, St Mungo's said Brian struggled in this respect; this was linked to his alcohol use and PTSD, which

had multiple triggers. There were also times when he would lose his ability to speak as he was experiencing flashbacks. Brian found clinical settings very difficult and would often 'shut down' or completely avoid appointments with medical and other professionals. Brian often relied on his St Mungo's/Thames Reach worker to advocate for him.

9.33 There certainly appears to be evidence that Brian, at least at times, may have lacked mental capacity, broadly attributable to his substance misuse and mental health, and that his mental capacity therefore fluctuated. Therein lies two problems that may present in the context of fluctuating capacity:

> 'a) a person is misidentified as having the material decision-making capacity, purports to refuse the act, and the act is not carried out on the basis of the apparently capacitous[16] refusal, and the person either suffers serious adverse consequences or dies; or b) a person is misidentified as lacking the material capacity, and an act is carried out in the face of what is, in fact, a capacitous refusal, giving rise to a breach of their Article 8 ECHR rights and liability on the part of the professionals concerned.'[17]

9.34 As such, practitioners need to be able to demonstrate clearly any determination that the person either has or lacks capacity. Where there are concerns about fluctuating capacity or decision making, practitioners need to be confident in utilising the Court of Protection or the inherent jurisdiction of the High Court. Agencies noted that the inherent jurisdiction of the High Court is either not well known or seen to be heavy handed, and that practitioners need to be supported to understand what it is and when to utilise it.

Equality and Diversity

9.35 The Equality Act 2010 provides the legal framework to protect the rights of individuals. The Act protects people against discrimination, harassment, or victimisation in employment, and as users of private and public services based on nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The protected characteristics pertinent in this case are age, disability, and race. This section also addresses aspects of Brian's lived experienced, such as his status as a veteran, and experience of homelessness and prison, which is not necessarily covered by the Equality Act 2010 but nevertheless affected his experience of accessing and using services, and service responses.

9.36 In relation to age there is a general preconceived notion that sees older people as having care needs, and yet in homeless pathways, due to the

[16] Having the legal capacity to do something.
[17] Mental-Capacity-Guidance-Note-Fluctuating-Capacity-in-Context-December-2021.pdf (39essex.com)

chaotic lifestyle of service users, care needs appear much earlier than in general population. Many services are geared at people who are much older, for example, extra care which often applies an age threshold, generally a lower age limit of 50 or 60 years of age. As the homeless cohort are often younger people with care needs this group are often excluded from such services. Conversely, substance misuse services available to, and focusing on, younger people, risks excluding older cohorts.

9.37 Under the Equality Act 2021 disability refers to any physical or mental impairment. Brian experienced a range of complex physical and mental health issues and practitioners reflected that there is a stigma attached to individuals with complex issues, and that services need to think about how they ensure professionals are equipped with the right skills and training to offer assessment, taking a joint approach with mental health professionals. Practitioners further reflected that working with dual-diagnosis is an issue across all London boroughs but that there are local plans to establish resource for this, with plans for a pilot with the aim to build a safer, friendlier system.

9.38 However, practitioners reflected that Brian was housed in several settings and always struggled when living alongside other people with their own complexities and diversities. This led to the decision to house Brian independently.

9.39 Around 66% of people in custody are loosely classified as having a personality disorder. Brian had a diagnosis of antisocial personality disorder. People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness, and associated behaviours including irresponsible and exploitative behaviour, recklessness, and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity, and a disregard for the feelings of others. Many people with antisocial personality disorder have a criminal conviction and are imprisoned or die prematurely as a result of reckless behaviour.[18] Funding has been secured for a forensic mental health practitioner in probation services in order to try and bridge the gap in working with people with personality disorder.

9.40 Whilst interventions for personality disorder work, they are very expensive and often would not be offered to someone with Brian's level of alcohol intake, resulting in a continuous vicious cycle. Turning Point suggested that sometimes we need to take the risk and try both approaches, mental health, and substance misuse, jointly.

[18] Overview | Antisocial personality disorder: prevention and management | Guidance | NICE

9.41 Brian was known to be racist and would display racist behaviour in various settings and towards professionals. Ethnicity was considered in terms of engagement given his racist behaviour. However, probation confirmed that Brian never attended more than once, on an occasion when he was allocated a white British worker he attended only twice. Practitioners stated that Brian could be aggressive to professionals from all backgrounds, and that he had had positive relationships with non-white professionals. One white British practitioner stated that Brian could be abusive to her also.

9.42 This practitioner recalled that Brian could also be charming and engaging; he was politically minded and knowledgeable about the military. However she also gave an example of having arranged for a blood test to be taken as part of his medical care, where Brian had demonstrated racist abuse towards the phlebotomist trying to take his bloods, and the conflict this created for her in that she felt she had put another professional in harm's way.

9.43 It was considered in light of this whether reasonable adjustments could have been made, such as whether this should impact on how staff are allocated, but this conflicted with the fact that such an approach would support racism, could promote such behaviour and would therefore be unreasonable.

9.44 The Equality Act does not include veterans or those experiencing homelessness as protected characteristics, however in 2011 the Government established the Armed Forces Covenant. The Armed Forces Covenant is 'a promise from the nation that those who serve or have served in the armed forces, and their families, are treated fairly'[19]. The Armed Forces Act 2021 amended the Armed Forces Act 2006 by inserting a legal duty (the 'Covenant Duty') on specified public persons and bodies, to have due regard to the principles of the Armed Forces Covenant when exercising certain statutory functions in the fields of healthcare, education, and housing. In practice this means removing disadvantage and preventing additional challenges in access to services for veterans and making special provision where necessary in order to achieve this[20].

9.45 The Liaison and Diversion service confirmed that they have specific pathways for homelessness and veterans as protected groups within the Criminal Justice system. Brian also had access to the veteran's services and housing services.

Engaging people

9.46 Brian was described as someone who was difficult to engage and was resistant to support that was offered. All agencies agreed that Brian was difficult to engage, he regularly moved and it was difficult to keep track of him,

[19] Armed Forces Covenant: guidance and support - GOV.UK (www.gov.uk)
[20] Armed_Forces_Covenant_Duty_Statutory_Guidance.pdf

or when he was due for release from prison. This was compounded by a lack of an identified lead professional, as discussed above.

9.47 Practitioners reflected that the biggest barrier to Brian receiving support was that he often declined it. His mental health influenced this and if he was frustrated then he would not engage. Repeated offers to engage were made by multiple agencies who, when he declined, would offer further opportunities to engage, visiting practitioners would respect his choice and would arrange for a follow-up visit the next day to try to re-engage. Even when Brian was choosing not to engage, support work was being completed to manage and mitigate risk such as to fix his heating and hot water and to reduce rent arrears.

9.48 Whilst action was taken to remind Brian of the need for compliance with TB medication and with the terms of his restraining order, as he was living in independent accommodation with visiting support; he had control over visitors into his property and whether he chose to engage with support and with statutory services such as social workers.

9.49 The combination of the physical and mental health issues Brian experienced likely placed him at greater risk of abuse, of neglecting his own needs and likely risked impairing his ability to make healthy choices. His personality disorder, and its characteristic of mistrust in others, may have further acted as a barrier to him seeking support.

9.50 Practitioners noted that difference in Brian's engagement in community and in prison, whereby he engaged well whilst in prison, with non-engagement resuming when he returned to the community. This was attributed to the structured environment of prison that Brian appeared to find easier to cope with, responding well to the routine and safety provided by the environment, and the result of being able to reduce alcohol and substance use. However, his sentences were too short to achieve any meaningful intervention.

9.51 Oxleas NHS Trust stated that discharge planning was attempted but this was difficult due to Brian's chaotic behaviour. Each time he was released from custody there were plans in place but often Brian chose to make alternative plans i.e., not returning to the accommodation that had been arranged, losing the mobile phone that had been given and that services were going to contact him on within hours of leaving custody, returning to alcohol immediately upon release and so not engaging as planned. Furthermore, services were often not aware of his release date, and he would be released in the evening when services were shut. Practitioners suggested exploring step down from prison into community services thus providing a window of opportunity for intervention.

9.52 The issues of engagement tie in closely with the factors already explored in this analysis such as equality and diversity and multi-agency working. Some

practitioners felt they could not do any more for Brian and attributed this to a lack of training on how to work with people experiencing PTSD and the challenge of engaging with someone who was regularly abusive and racist to staff. ICHT said their services and teams were able recognise 'difficult to engage' patients as they often present with challenging behaviours as a result of their mental health or substance misuse. However, preconceived attitudes also contribute to the difficulty of recognising and acting upon these vulnerabilities. Practitioners recognised that repeat referrals may be a cause for concern and escalation, and an indication of non-compliance but this requires coordination and sharing of information between agencies. Probation also commented on the dual role of protecting victims and working with perpetrators, with the needs of the victim being prioritised.

9.53 Systems issues were also highlighted as a barrier to engagement such as the focus of hospital discharge teams to push for discharge, and insisting people go back to their homeless hostel. This is a live discussion for a whole cohort of people, and there is exploration of a specialist social worker for the assessment of hostel clients. There was also the factor of the 'red card', so whilst Brian was able to access the emergency department, had he required admission his care would have needed to be transferred to another hospital who possibly did not know him as well and would be unfamiliar to him. There is a culture of clients being seen as second-class citizens, excluded from the care system as they are seen as 'too complicated'; practitioners said there is an element of trying to effect systemic changes, and changing NHS culture to remedy this.

9.54 Brian did engage well with the Veteran's Service who supported him whilst in custody and in the community. He got on very well with his worker who attended hospital TB appointments with him to encourage compliance.

9.55 It is important when professionals attempt to engage with difficult to reach adults that they apply the key principles of respect, equality, partnership, social inclusion, and empowerment. Practitioners should show compassion and understanding of the complexity of the person's background and how this has led to their current circumstances and why they are resistant to services and support. To maximise engagement consideration should be given to:

- Who is best placed to work with and build a trusting relationship with the adult, and who should be the lead professional/agency? Who else can support with this, e.g., a family member, advocate, other professional?
- Find the right tone. It is important to be honest about potential consequences while being non-judgemental and separating the person from the behaviour.
- Progress at the adult's pace. Allow conversations to take place over a period, and to focus on finding what motivates the person.

- Ensure that the adult receives information about practical options for support in a format they can understand. Check whether the person understands these options and the consequence of their choices.
- If there is doubt about a person's mental capacity, carry out a decision specific mental capacity assessment.
- Develop a plan which clearly sets out options and agreed actions. It is important to offer choices and have respect for the person's judgement.
- Ensure the person is involved as much as possible, for example making sure the person is invited to attend meetings.
- It is also important that front-line practitioners have access to effective supervision and training within their organisation.[21]

9.56 At a strategic level consideration should also be given as to how systemic and organisational culture might impact on accessibility.

Impact of COVID-19

9.57 In March 2020, the UK Prime Minister introduced a nationwide lockdown. All non-essential contact and travel was prohibited, and many services moved to remote working. Restrictions began to ease in July 2020 and people were able to meet up in limited numbers outside. There was further easing of restrictions in August 2020.

9.58 There was a further national lockdown introduced for four weeks on the 2nd November 2020, and from the 21st December 2020 London and the Southeast entered its third lockdown; this was extended nationwide on the 6th January 2021. The 'stay at home' order was finally lifted on the 29th March 2021 with most legal limits on social contact being removed on 19th July 2021[22].

9.59 Practitioners reflected on how the Covid-19 pandemic impacted on ways of working. HIV services, although limited, were mainly carried out virtually, face to face appointments were not routinely offered. Emergency Department services remained open, and Brian could have presented there if unwell. Brian was diagnosed with Pulmonary TB in May 2021 and the TB service was open and operating as usual and offered regular home visits.

9.60 However, many staff, especially during and since the Covid-19 pandemic, experienced burn out, which was made harder by patients who are abusive to staff as a result of their mental health or substance misuse, as Brian was on multiple occasions.

[21] Complex-cases-audit-learning-briefing.pdf (eastsussexsab.org.uk)
[22] timeline-coronavirus-lockdown-december-2021 (instituteforgovernment.org.uk)

9.61 The pandemic and associated restrictions impacted Brian who was affected by less people being around and not being able to beg for money as he usually would, as a result of the 'stay at home' directive.

9.62 Conversely, the pandemic in many ways helped Brian. It made it easier for him to manage his prescriptions as staff were able to collect them for him and he was also able to access accommodation quickly. In non-pandemic times there would likely have been more barriers to him accessing accommodation. Medical appointments were predominantly conducted remotely via telephone or online, this again was an advantage as clinical settings were a big trigger for him.

Good Practice

10.1 There were several areas of good practice identified. This included the close work and communication between Thames Reach and the TB nurse in the months before Brian's death which was marked by mutual support when making difficult decisions with regards to Brian. There was also evidence of a good multi-agency approach taken to planning Brian's releases from prison and return to his accommodation.

10.2 There was flexibility of medical professionals working with Brian, as evidenced when the TB nurse supported him in taking his TB medication on his doorstep and who would actively seek him in areas where he was known to frequent when they called at his accommodation and he was not there. The value of the development of a trusting relationship between the TB specialist community nurse was demonstrated. The nurse reported a level of worry when approaching Brian and was aware of triggers to his behaviour. She also reported awareness of the impact of adverse childhood experiences in understanding the context of decisions Brian had made. In the context of this relationship, Brian was able to articulate a sense of hope for his future with the TB specialist at least in terms of his hope to secure accommodation in a flat dedicated to veterans in Hammersmith.

10.3 There was significant engagement from a lot of professionals despite Brian's difficulty to engage with this. Brian's Thames Reach worker understood the challenges Brian faced and was very flexible in how they would communicate and engage him.

10.4 There were reports of staff making significant adjustments to care routines when he was an inpatient to accommodate his wishes, and opportunities were made to connect Brian with mental health services when he presented at the Emergency Department.

10.5 All professionals responded quickly to communicate with Thames Reach staff and to act as requested and there were examples of good joint working with

Social Services to attempt to complete assessments, to resolve arrears and to share information on the status of Brian's health.

Areas for development

11.1 The following have been identified as areas of development:

- An understanding and application of intersectionality[23] and trauma informed practice with regards to protected characteristics and lived experience, and how these impact upon accessibility of services, service responses and engagement of clients,
- Competence in assessing mental capacity of people who use alcohol and/or substances and for people whose mental capacity fluctuates,
- Clear evidence-based recording of determinations of mental capacity (whether that is that the person *lacks* or *has* capacity),
- An understanding of the importance of multi-agency forums for identifying and managing risk, with an awareness of the multi-agency forums available in the area, their remit and referral processes,
- Recognition of the impact on workers who work with people with complex needs and who exhibit racist behaviour, and the effect upon workers when a client dies.
- An awareness of the benefits of identifying a lead professional to coordinate and have overall oversight of complex cases

Recommendations

Training

12.1 A training package should be developed and/or commissioned to improve practitioners understanding of the application of the Mental Capacity Act, with a focus on the assessment of mental capacity for people who use alcohol and/or substances, and for people whose mental capacity fluctuates.

12.1.1 This includes all agencies ensuring there are clear evidence-based recording of determinations of mental capacity (whether that is that the person *lacks* or *has* capacity).

12.2 The SAB to raise awareness of the Inherent Jurisdiction of the High Court through training, briefings, and sharing resources and case law examples.

12.3 For the SAB and its partners to consider support available to frontline workers to enable them to be sufficiently skilled and confident to effectively

[23] "Intersectionality is a concept for understanding how aspects of a person's identities combine to create different and multiple discrimination and privilege. Examples of these aspects are gender, race, sexuality, religion, disability or age". (NHS England)

work with people who are difficult to engage by developing and disseminating learning resources and guidance

12.3.1 For the SAB to develop plans to increase understanding and application of the principles of intersectionality and trauma informed practice as part of this work.

12.4 Develop and deliver training to agencies on the completion of IMRs to ensure quality and consistency.

Support for staff

12.5 The SAB and its partner agencies to review local policy and processes for challenging racism and abuse towards staff to ensure there is a shared understanding of how such challenging cases will be approached. The Norfolk SAB's 7-minute briefing 'Managing racial abuse towards staff from people who lack capacity' may be helpful in supporting this work.

12.5.1 For agencies to recognise the impact on workers who experience trauma in the course of their work and make provision for supporting practitioners through existing wellbeing services.

Case management

12.6 The SAB to explore how the needs of people with complex needs and/or challenging behaviour can be best met by all agencies in a joint and coordinated way by reviewing existing multi-agency frameworks to consider how this supports identification of a lead professional/agency in complex cases and the promotion of expected best practice.

12.6.1 For this to include development and dissemination of a learning resource on the importance of multi-agency forums for identifying and managing risk, including the promotion of multi-agency forums available in the area.

12.6.2 For this to include consideration of a framework for working with complex cases that includes identification of a lead professional for the purposes of coordination and overall oversight, and the identification of agency leads in each of the agencies involved to act as a single point of contact and minimise the risks identified in paragraph 9.22.

Single agency recommendations

Oxleas NHS Trust

12.7 Better release planning for prisoners who are released out of hours with consideration of a multiagency discharge lounge.

12.8 Increased joined up work with the court if they are releasing people with complex needs, to ensure ongoing care has been co-ordinated.

ICHT

12.9 Reinforce the importance of formal mental capacity assessments. Mental capacity assessments should be formally documented to justify and evidence a patient's decision-making abilities.

12.10 Teams through supervisions and training to be reminded of the importance of organised and timely discharges, with all the 'key' contacts in the community (who patients receive support from) contacted and involved in the discharge planning process.

Veteran's service

12.11 Referrals from HMP Wandsworth to Operation Courage services should include any identified risks and this needs to be updated in the operational policy.

12.12 Protocol to be written into operational policy concerning managing referrals where the plan is to offer a consultation rather than assessment/treatment.

12.13 Outcomes of consultations to be communicated to the GP, referrer, and other involved services.

12.14 Key known risks to be reviewed and communicated with all involved services including GP before case is discharged.

12.15 All staff across Operation Courage Services to be reminded a) when making referrals or discharging clients that all risk factors are reviewed and communicated to relevant services, b) that all key risks at discharge are presented and considered in MDT and/or in supervision.

12.16 If safeguarding concerns are not taken up by local councils, service to proactively follow up and consult with Trust Safeguarding Lead regarding means of escalation. Action to be added to operational policy.

12.17 All staff to be reminded of the importance of documenting all risk information in the risk assessment section in Care notes.

12.18 All staff to be reminded of the importance of documenting outcomes of meetings clearly in the notes.

Probation

12.19 To evidence a decision to make or not to make an Adult Safeguarding referral to Adult Social Care.

Cassidy Medical Centre

12.20 Ensure the relevant staff undertake Mental Capacity Act Level 3 refresher training.

12.21 Make every contact count: to share the SAR 7-minute briefing with the GPs to use as an opportunity for reflective practice, giving the practice an opportunity to consider where and how an MDT approach can be optimised in complex vulnerable patients such as Brian.

Turning Point

12.22 To review the provision of enhanced engagement prior to release and according to treatment and support needs.

12.23 Ensure more offers of assessment prior to release, through the gate support

12.24 Raise awareness of multi-agency risk management and the multi-agency risk forums available.

12.25 Ensure the scheduling of a face-to-face appointment for key-working support and medical interventions.

Court liaison

12.26 To ensure clear documentation as whether mental capacity has been considered.

Adult Social Care, Hammersmith and Fulham Council

12.27 To review thresholds and responses to safeguarding concerns that involve self-neglect/alcohol use/mental capacity.

12.28 High Risk Panel to be reviewed and revamped to widen its ‘reach’. To consider panel members and chair as appropriate.

12.29 Review the remit of ASC substance misuse team to enable faster access to services for detox.

12.30 Specific training on mental capacity and self-neglect (including the use of inherent jurisdiction).

Conclusion

13.1 Brian experienced a revolving door of services moving between prison and the community with frequent attendances at hospital. He experienced several complexities in relation to his physical and mental health which needed to be understood in the context of his lived experienced, such as his experience of serving in the army and his status as a veteran, his experience of

homelessness, and as an offender who had experienced frequent custodial sentences.

13.2 There were several agencies and services seeking to support Brian but this presented its own challenges due to a lack of an effective multi-agency approach which would seek to achieve coordination, information sharing, care planning and risk assessment and management.

13.3 Brian was difficult to engage and whilst he formed positive relationships with some professionals, issues with compliance remained and it continued to be difficult to support him and positively affect his wellbeing. Brian was clear about his wishes, for example, to continue to use alcohol, and he was deemed to have capacity to make unwise decisions although this capacity was never formally assessed and evidenced.

13.4 Brian had experienced abuse from others in the past and by virtue of his vulnerabilities he continued to be at risk from others. However, the assault that occurred on, or in the days before, the 10th February 2022 was not foreseen and the courts determined that it could not be directly linked to Brian's death. The practitioners involved in this case felt that they had done everything they could to support Brian with the resources and legal remit available to them and they have been able to identify areas for development and have made recommendations for their own services areas.